BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LISA ANN ADLER 1066 Calle Del Cerro, 1401 San Clemente, CA 92672 Registered Nurse License No. 452297 Respondent.	Case No. 2003-189 OAH No. L-2003040052

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on March 31, 2004.

It is so ORDERED March 2, 2004.

Sandra K. Erickson

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LISA ANN ADLER 1066 Calle Del Cerro, 1401 San Clemente, CA 92672 Registered Nurse License No. 452297 Respondent.	Case No. 2003-189 OAH No. L-2003040052 **STIPULATED SURRENDER OF LICENSE AND ORDER**

In the interest of a prompt and speedy resolution of the matter, consistent with the public's interest and response of the Board, the parties hereby agree to the following Stipulated Surrender of License and Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Bill Lockyer, Attorney General of the State of California, by Gillian E. Friedman, Deputy Attorney General.

2. Lisa Ann Adler (Respondent) is representing herself in this proceeding and has chosen not to exercise her right to be represented by counsel.

3. On or about March 31, 1990, the Board of Registered Nursing issued Registered Nurse License No. 452297 to Lisa Ann Adler. The License was renewed in inactive status and and will expire on September 30, 2003, unless renewed.

JURISDICTION

4. Accusation No. 2003-189 was filed before the Board of Registered Nursing (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 12, 2003. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 2003-189 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 2003-189. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of her legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at her own expense; the right to confront and cross-examine the witnesses against her; the right to present evidence and to testify on her own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 2003-189, agrees that cause exists for discipline and hereby surrenders her Registered Nurse License No. 452297 for the Board's formal acceptance.

9. Respondent understands that by signing this stipulation she enables the Board to issue an order accepting the surrender of her Registered Nurse License without further

process.

RESERVATION

10. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Board of Registered Nursing or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

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ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 452297, issued to Respondent Lisa Ann Adler is surrendered and accepted by the Board of Registered Nursing.

14. The surrender of Respondent's Registered Nurse License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

15. Respondent shall lose all rights and privileges as a Registered Nurse in California as of the effective date of the Board's Decision and Order.

16. Respondent shall cause to be delivered to the Board both her License wall and pocket license certificate on or before the effective date of the Decision and Order.

17. Respondent fully understands and agrees that if she ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2003-189 shall be deemed to be true, correct, and admitted by Respondent when the Board determines whether to grant or deny the petition.

18. If and when respondent's license is reinstated, she shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of Two Thousand Three Hundred One Dollars and Twenty Five Cents ($2,231.25). Respondent shall be permitted to pay these costs in a payment plan approved by the Board. Nothing in this provision shall be construed to prohibit the Board from reducing the amount of cost recovery upon reinstatement of the license.

19. Should Respondent ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other heath care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 2003-189 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of

Issues or any other proceeding seeking to deny or restrict licensure.

20. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board of Registered Nursing's Decision and Order.

ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 10/15/03.

LISA ANN ADLER
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

DATED: 10/20/03.

BILL LOCKYER, Attorney General
of the State of California

GILLIAN E. FRIEDMAN
Deputy Attorney General

Attorneys for Complainant

DOJ Docket Number/Matter ID: 03579110-SD2002AD0719
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Exhibit A

Accusation No. 2003-189

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LISA ANN TOWERS,** **A.K.A. LISA ANN ADLER,** **A.K.A. LISA ANN TOWERS ADLER** *1100 Calle Del Cerro #118* San Clemente, CA 92672 **Registered Nurse License No. 452297** Respondent.	Case No. 2003-189 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 31, 1990, the Board of Registered Nursing ("Board") issued Registered Nurse License Number 452297 to Lisa Ann Towers, a.k.a. Lisa Ann Adler, a.k.a. Lisa Ann Towers Adler (hereinafter "Respondent"). The license was renewed in inactive status and will expire on September 30, 2003, unless renewed.

STATUTORY PROVISIONS

3. Section 2734 of the Business and Professions Code ("Code") provides:

"Upon application in writing to the board and payment of the biennial renewal fee, a licensee may have his license placed in an inactive status for an indefinite period

of time. A licensee whose license is in an inactive status may not practice nursing. However, such a licensee does not have to comply with the continuing education standards of Section 2811.5."

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 of the Code provides:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct . . ."

6. Section 2762 of the Code provides:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

". . . . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

7. Health and Safety Code section 11350(a) provides, in pertinent part, that except as otherwise provided in this division, every person who possesses (1) any controlled substance specified in subdivision (b) or (c), or paragraph (1) of subdivision (f) of Section 11054, specified in paragraph (14), (15), or (20) of subdivision (d) of Section 11054, or specified in subdivision (b), (c), or (g) of Section 11055, or (2) any controlled substance classified in

Schedule III, IV, or V which is a narcotic drug, unless upon the written prescription of a physician, dentist, podiatrist, or veterinarian licensed to practice in this state, shall be punished by imprisonment in the state prison.

8. Health and Safety Code section 11173 provides:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact. . . ."

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

10. "Demerol" is a brand of meperidine hydrochloride, a derivative of pethidine, and is a Schedule II controlled substance as designated by Health and Safety Code section 11055(c)(17).

11. "Vicodin" is a compound consisting of 500mg. acetaminophene per tablet and 5mg. hydrocodone bitartrate also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4).

12. "Vistaril" is a brand of hydroxyzine hydrochloride, is a dangerous drug within the meaning of Business and Professions Code section 4211 in that it requires a prescription under federal law.

FIRST CAUSE FOR DISCIPLINE

(Obtaining, Possessing, and Self-Administering a Controlled Substance)

13. Respondent's license is subject to disciplinary action under section 2761(a) and section 2762(a) of the Code in that on diverse occasions from on or about November 27, 2000, to on or about March 10, 2001, while employed as a registered nurse at Mission Hospital located in Mission Viejo, California, Respondent, through fraud, deceit,

misrepresentation, subterfuge, or by the concealment of a material fact, obtained, possessed, and self-administered Demerol (Meperidine) without a prescription therefor and without any other legal authority in violation of Health and Safety Code section 11150 and section 11173.

SECOND CAUSE FOR DISCIPLINE

(Making False or Grossly Inconsistent Record Entries)

14. Respondent's license is subject to disciplinary action under section 2761(a) and section 2762(e) of the Code in that Respondent, while employed as a registered nurse at Mission Hospital located in Mission Viejo, California and at Irvine Regional Hospital located in Irvine, California, committed the following acts, involving false, grossly incorrect, or grossly inconsistent entries in a hospital, patient, or other record pertaining to a controlled substance:

a. **Patient #1**: On or about March 10, 2001, at 7:31 a.m., while employed as a registered nurse at Mission Hospital, Respondent obtained 50mg. of Demerol for administration to Patient #1 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

b. **Patient #2**: On or about March 10, 2001, at 8:35 a.m., while employed as a registered nurse at Mission Hospital, Respondent obtained 50mg. of Demerol for administration to Patient #2. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

c. **Patient #3**: On or about February 14, 2001, at 3:18 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained 50mg. of Demerol for administration to Patient #3 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

d. **Patient #4**: On or about February 17, 2001, at 11:09 a.m., while employed as a registered nurse at Mission Hospital, Respondent obtained 50mg. of Demerol for

administration to Patient #4 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

e. **Patient #5**: On or about February 15, 2001, at 6:41 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained 100mg. of Demerol for administration to Patient #5 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

f. **Patient #7**: On or about February 14, 2001, at 1:11 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained 50mg. of Demerol for administration to Patient #7 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

g. **Patient #10**: On or about February 13, 2001, at 05:00 a.m. and at 4:11 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 150mg. of Demerol for administration to Patient #10 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

h. **Patient #11**: On or about February 15, 2001, at 3:38 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained 75mg. of Demerol for administration to Patient #11 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

i. **Patient #16**: On or about February 23, 2001, between 9:58 a.m. and 7:11 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained a Demerol in the total dosage amount of 950mg. of Demerol for administration to Patient #16 without a physician's order to do so. Thereafter, Respondent failed to document or record the

administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

j. **Patient #17**: On or about March 9, 2001, at approximately 5:07 p.m. and at approximate 5:51 p.m. while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 200mg. of Demerol for administration to Patient #17 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

k. **Patient #18**: On or about February 24, 2001, at 3:33 p.m., 4:18 p.m. and at 4:53 p.m. while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 200mg. of Demerol for administration to Patient #18 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

l. **Patient #19**: On or about February 25, 2001, at 1:59 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained 75mg. of Demerol for administration to Patient #19 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

m. **Patient #22**: On or about March 4, 2001, at approximately 3:38 p.m. while employed as a registered nurse at Mission Hospital, Respondent obtained 100mg. of Demerol for administration to Patient #22 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

n. **Patient #23**: On or about March 7, 2001, at approximately 4:30 p.m. and at 6:04 p.m. while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 100mg. of Demerol for administration to Patient #23 without a physician's order to do so. Thereafter, Respondent failed to document or record the

administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

o. **Patient #24**: On or about March 4, 2001, at 9:41 p.m., 12:03 p.m., and at 5:15 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 300mg. of Demerol for administration to Patient #24. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

p. **Patient #25**: On or about March 9, 2001, at 7:44 a.m., and 1:32 p.m. while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 500mg. of Demerol for administration to Patient #25 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

q. **Patient #26**: On or about March 9, 2001, at 8:37 a.m. and 2:26 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 150mg. of Demerol for administration to Patient #26. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

r. **Patient #27**: On or about March 7, 2001, at 4:10 p.m. and 7:05 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 100mg. of Demerol for administration to Patient #27 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

s. **Patient #28**: On or about February 15, 2001, at 11:36 a.m. and 4:54 p.m., while employed as a registered nurse at Mission Hospital, Respondent obtained a total dosage of 200mg. of Demerol for administration to Patient #28 without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of 150mg. of

Demerol on the patient's medication administration record, or to otherwise account for the disposition of the medication.

t. **Patient "A"**: On or about November 27, 2000, at 8:09 a.m.,10:52 a.m. and 12:59 p.m., while employed as a registered nurse at Irvine Regional Hospital, Respondent obtained a total dosage of 200mg. of Demerol for administration to Patient "A" without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

u. **Patient "C"**: On or about November 28, 2000, at 9:39 a.m. while employed as a registered nurse at Irvine Regional Hospital, Respondent obtained 7.5mg. of Vicodin for administration to Patient "C." Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

v. **Patient "E"**: On or about November 28, 2000, between 9:30 a.m. and 2:35 p.m., while employed as a registered nurse at Irvine Regional Hospital, Respondent obtained a total dosage of 300mg. of Demerol for administration to Patient "E" without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

w. **Patient "F"**: On or about November 27, 2000, at 2:25 p.m., while employed as a registered nurse at Irvine Regional Hospital, Respondent obtained 75mg. of Demerol for administration to Patient "F" without a physician's order to do so. Thereafter, Respondent failed to document or record the administration of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

x. **Patient "H"**:

1. On or about November 27, 2000, at approximately 3:40 p.m., while employed as a registered nurse at Irvine Regional Hospital, Respondent obtained 100mg. of Vistaril for administration to Patient "H" without a physician's order to do so.

Thereafter, Respondent failed to document or record the administration of 75 mg. of the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

2. On or about November 28, 2000, at approximately 06:46 a.m. and 10:36 a.m., while employed as a registered nurse at Irvine Regional Hospital, Respondent obtained a total dosage of 150mg. of Demerol for administration to Patient "H." Thereafter, Respondent failed to document or record the administration of the medications on the patient's medication administration record, or to otherwise account for the disposition of the medication.

y. **Patient "I"**: On or about November 28, 2000, at 8:37 a.m., while employed as a registered nurse at Irvine Regional Hospital, Respondent obtained 75mg. of Demerol for administration to Patient "I" without a physician's order to do so. Thereafter, Respondent failed to document or record the administration the medication on the patient's medication administration record, or to otherwise account for the disposition of the medication.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 452297 issued to Lisa Ann Towers, a.k.a. Lisa Ann Adler, a.k.a. Lisa Ann Towers Adler;

2. Ordering Lisa Ann Towers, a.k.a. Lisa Ann Adler, a.k.a. Lisa Ann Towers Adler to pay the reasonable costs incurred by the Board in the investigation and enforcement of this case pursuant to section 125.3 of the Code;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 2/21/03

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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